Juvenile Justice

MISSOURI ALLIANCE FOR YOUTH: A PARTNERSHIP BETWEEN DMH AND JUVENILE JUSTICE

Winter 2003

The Missouri Alliance for Youth: A Partnership Between DMH and Juvenile Justice is dedicated to improving services for youth with mental health needs in the juvenile justice system. We hope to use this forum to keep interested parties informed on local, regional, state and national happenings in the area of mental health and juvenile justice. Comments and suggestions regarding the format or content are always welcome and can be sent to:

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The MO MAYSI Project: DYS Report

One goal of the Strategic Plan of the Missouri Alliance is to identify the mental health needs of children and youth who are served by the juvenile and family courts and to educate the public and general assembly about these needs. The MO MAYSI project is one mechanism by which the Alliance can achieve this goal. The MO MAYSI Project has two goals. The first goal is to obtain prevalence data on Missouri youth involved in the juvenile justice system who may have mental health needs. To achieve this goal data was collected on a sample of youth in Missouri who were in detention, committed to the Division of Youth Services (DYS) or referred through community intake through the juvenile office. In the Summer 2002 edition of this newsletter the results for youth in detention was provided. In this edition the data obtained on youth committed to DYS is provided.

The MAYSI-2 is a 52 question self-report instrument designed by Thomas Grisso, Ph.D. and Richard Barnum, MD to assist juvenile justice personnel in identifying youths 12-17 years of age who may have special mental health needs. The MAYSI-2 requires no more than 15 minutes to administer and can be scored and interpreted quickly without the expertise of a mental health professional. The MAYSI-2 has a fifth grade reading level. Youths circle yes or no to each item concerning whether it is true for them "within the past few months". Youth's answers are then scored on 7 scales for males and 6scales for females with each scale containing 5-9 items. The authors have suggested two cut-off scores to determine if a youth requires additional attention. The first is a "caution" score. If a youth has scored at this level it may reflect "possible clinical significance" as might be reflected on more in-depth but parallel assessment. Scores in the "warning" zone are "intended to alert staff that the youth has scored exceptionally high in comparison to other youth in the juvenile justice system". The warning cut-off scores were set at the point that identifies "approximately the top 10% of youths on a given MAYSI-2 scale". The seven scales on the MAYSI-2 are : Alcohol/Drug Use, Angry–Irritable, Depressed-Anxious, Somatic Complaints, Suicide Ideation, Thought Disturbance (males only) and Traumatic Experience. The MAYSI-2 does not provide a diagnosis, nor should it be construed that a high score relates directly to a specific diagnosis. The MAYSI-2 is a screening tool that is designed to serve as an "alerting function" for juvenile justice staff that a youth may require further questioning, increased monitoring/ Supervision referral for a mental health assessment or referral for an emergency screening. Additionally, a youth's response on the MAYSI-2 may reflect a transient emotional response to their current legal situation and detention. Upon adjustment to, or resolution of, their legal situation, a youth responses to the MAYSI-2 may be very different. However admission to detention can be very stressful and prompt a maladaptive behavioral response that requires intervention.

In preparation for the kick-off of the MO MAYSI Project, Dr. Grisso met with members of the MO Alliance Steering Committee and other interested stakeholders in February of 2000 to discuss systemic issues that would impact the project as well as guiding the use of the instrument. Dr. Barnum and Dawn Peuschold, Ph.D. met with staff from participating detention centers and community mental health

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MISSOURI DEPARTMENT OF MENTAL HEALTH

Division of Alcohol & Drug Abuse
(ADA)

Division of Comprehensive Psychiatric Services
(CPS)

Division of Mental Retardation & Developmental Disabilities
(MRDD)

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centers in April of that same year regarding administration and utilization of the MAYSI-2. The University of MO –Columbia's Dept. of Educational and Counseling Psychology conducted the data analysis. Data from DYS was collected from approximately October through December of 2000

Results on Youth Committed to DYS

Approximately 233 youth committed to DYS were administered the MAYSI-2 along with the questions pertaining to demographic information, committing offense and mental health history. The following is a brief description of the youth who were administered the MAYSI-2 prior to their placement within DYS

- **82.8% of participants were male**
- **73.1% of participants were Caucasian, 20.3 were Black**
- **99.6% were aged 12 to 17 years, inclusive**
- **The largest age group was16 years old, representing approximately 41.9% of the participants**
- **The two largest categories of offense leading to commitment were: Theft (34.3%) and Assault Weapons (27.5%)**
- **42.1% of youth reported having a history of previous mental health services**
- **26.6% reported being prescribed some type of psychotropic medication with over a third reporting having been prescribed an anti-depressant medication**
- **Over half the youth reporting being prescribed a psychotropic medication reported being prescribed two or more medication**

MAYSI-2 PROFILES

The following table provides the percentage of youth who fell in the Caution or Warning zone for six of the seven scales.

Scale	Caution	Warning
Alcohol/Drug	30.1%	10.9%
Angry-Irritable	31.3%	14.3%
Depressed-Anxious	23.6%	8.9%
Somatic Complaints	40.4%	9.8%
Suicide Ideation	4.9%	15.7%
Thought Disturbance (Males Only)	25.8%	11.8%

Traumatic Experiences – The scale to measure Traumatic Experiences is different than the other scales. First, rather than focusing on the "past few months", questions for this scale are asked in the context of the youth's entire lifetime. Additionally separate Traumatic Experiences scales were developed for males and females. Finally, for this scale a youth's score is the number of statements related to traumatic experiences that they endorsed. No caution or warning cutoffs are provided for this scale, rather a youth's score can be compared to, at this time, the mean score obtained by the author's in their original studies. The authors obtained mean scores of 2.19 for girls. Missouri's average score for girls committed to DYS was 2.49. The authors obtained a mean score of 2.06 for boys. Missouri obtained a mean score of 2.02 for boys committed to DYS.

Co-Occurring Substance Abuse – National data has shown a high rate of co-occurring substance abuse and emotional disorder. In the Missouri DYS population administered the MAYSI-2, 79 scored in the caution or warning Alcohol/Drug Scale. Of these youth, the following percentage also scored in the caution or warning zone on another scale.

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SYSTEM OF CARE FOR CHILDREN, YOUTH AND FAMILIES

A system of care is a comprehensive array of supports and services which are organized in a coordinated way to meet the multiple and changing needs of children and youth with mental health needs and their families. However, a system of care is more than an array of services, it is a philosophy about the way in which children, youth and families receive services. Partnerships at all levels between families, providers, communities, regions and the state are fundamental to an effective system of care.

VALUES FOR SYSTEM OF CARE

- The system of care shall be community based, with the focus of services, as well as management and decision-making responsibility resting at the community level.
- The system of care shall be culturally competent, with agencies, programs, and services responsive to the cultural, racial, and ethnic differences of the populations they serve.
- The system of care shall nurture the development of natural supports for the child and family in their own home and community.
- The system of care shall insure access, quality, respect, choice, and accountability and strive for positive outcomes.
- The system of care shall support collaboration, partnership and integration at all levels – child and family, provider, community, regional and state.

The purpose of a System of Care (SOC) is to work to assure an integrated mental health treatment system across all child-serving agencies for children and youth with mental health needs, whether it be emotional/psychiatric, substance abuse and/or developmental disabilities. These children are identified by their families, schools, DFS, DYS or through the juvenile office. Each system meets some of the child's and/or their family's needs. No one agency can meet all the needs of the child and/or family. Collaboration is essential to effectively and efficiently address these needs.

System of Care establishes an interagency infrastructure at state and local levels to develop and implements services to support children and youth in their home and communities; aid in re-integration and transition for children/youth who have been placed out of their home and community; establish standards for mental health treatment and service delivery, prevention and early intervention; establish processes to share resources, leverage use of existing resources and advocate for needed resources and to establish and interagency quality assurance system to assess treatment outcomes, capacity, cost effectiveness, impact on systems, functional achievements and system involvement.

Local policy teams are made up of administrators/ supervisors from representative agencies who can address and commit to policy and funding issues. Any agency representative can refer a child to the local policy team when system barriers impact the progress of the child/family. The Local Policy Team has identified and committed resources that can be used to support children and family from the local community. When these resources and the Local Policy team's commitment and collaboration are unable to directly address needs or barriers, the State System of Care Team is contacted to examine the issues and work together to identify the impact of the issue, and possible state-level strategies to address/remove the barrier.

This summer the Dept. of Mental Health in collaboration with the Divisions of Family Services and Youth Services, Dept. of Elementary and Secondary Education, and the Office of State Courts Administrator/juvenile courts identified five sites to pilot a System of Care for Children, Youth and Families. These sites include Butler County, St. Louis City/County, Adair County, Greene County and Jackson County. Additionally, local interagency groups in Jefferson County and St. Charles County have volunteered to also develop local system of care policy teams. The State Level System of Care Team has been meeting for over a year to plan for, and support, the local policy teams. Some of the issues that have been addressed by the State SOC team include confidentiality and sharing of information, team representation, family participation, development of a memorandum of agreement, and development of other agreements.

"Many children experiencing severe mental health problems have been referred to the Board, and have significantly benefited from their participation in the system of care project."

Gilbert Alderson, Juvenile Officer 23rd Circuit
Chair, Jefferson County Children's SOC Board

St. Louis County actually was an initial pilot for developing a system of care for children through passage of HB503 in 1989. The intent of the legislation was to have a demonstration project that provided services that enable children who are seriously emotionally disturbed to remain with their families, make

YOUTH SCORING ON ALCOHOL/DRUG SCALE

Angry-Irritable	54.4%
Depressed-Anxious	44.3%
Somatic Complaints	60.8%
Suicide Ideation	24.1%
Thought Disturbance (boys only)	38.0%

Finally in examining scores across the scales, approximately 77% of the youth scored in the caution or warning zone on at least one scale. Since only 42% reported any type of history of receiving mental health services, this may indicate that we are not identifying youth who may require some type of mental health service prior to the commitment to DYS.

However this may also reflect the transient emotional state of youths who have recently been adjudicated and committed to the DYS.

In conclusion, although the MAYSI-2 is a screening tool and does not necessarily reflect chronic emotional problems, this data may suggest that upon commitment to the DYS approximately 75% of youth may display some level of at least transient emotional response that may require increased supervision/monitoring or services. With the higher federal mandate for health services for youth in custody, this study would suggest the need for a screening mechanism for a youth's emotional/mental health needs as well as access to increased monitoring, clinical assessments and a continuum of services to meet their individual needs.

System of Care for Children, Youth and Families (continued)

academic progress in public schools and decrease involvement in the juvenile justice system. The 503 Project was designed as a community-based, locally controlled, interagency treatment program. In addition to the Dept. of Mental Health providing intensive case management and wraparound services, the Departments of Elementary and Secondary Education and Social Services entered into the partnership to support the treatment program. The 503 Project was implemented as a 3 year demonstration project with an evaluation component built in to assess the cost benefit and effectiveness of treatment. Between 1991 and 1994 100 children were served in St. Louis County through the 503 Project. Prior to the initiation of this project minimal publicly funded community-based treatment services were available. The youth referred to the 503 Project were described as extremely high need and currently in or at risk of long-term placement out of the home either through the juvenile courts, DFS or DYS.

The outcome of the evaluation indicated that 92% of the families participating were satisfied or very satisfied. The Project services were able to reduce time in out of home placements by 72%. Approximately 95% of the youth were served in their own community (St. Louis). The cost of the services was approximately 25% less than the previous alternative services.

"An indirect benefit of the System of Care model is that relationships have been formed among key decision makers, cutting red tape and helping to promote systemic change."

Lew Mueller
DYS Regional Administrator

Although the 503 Project was a good start, it was not able to accomplish all that was hoped. The evaluation report noted that the 503 Project did not create a "system of care" but a program. Some challenges not initially met by the end of the 503 Project included 1) Pooling or sharing of resources between agencies; 2) child-serving agencies "dropping out" after the referral is accepted; 3) inability to remain involved after improvement to help child/youth and family maintain progress; and 4) limited impact on creating flexible dollars.

The 503 Board, made up of multiple child-serving agencies, that oversaw the project however committed to continuing their efforts towards developing a system of care in St. Louis County. This group continued to meet and address systemic issues that impact services and supports for children, youth and families. Through these efforts involved agencies were able to continue to refer to the community mental health center (once Great Rivers Mental Health Services, now BJC Behavioral Health Care) and have services prioritized. Through these efforts the Board has made gains in sharing of resources, creating more flexible dollars and examining such issues as transitional issues for youth who are turning 18 and youth with co-occurring disorders. The Board has helped develop joint programs such as treatment family homes for youth with developmental disorders and intensive community-based services for children in the custody of DFS to bring them out of Level 4+ placements. The Board expanded from St. Louis County into St. Louis City in 2001.

Due to their extensive history and successes, the St. Louis Board (now the St. Louis City/County System of Care Board) has provided consultation to state level representatives and other local boards in creating a system of care. The four other sites have been making progressing in developing a local system of care.

Greene Co. – Awarded a $9 million dollar federal grant through Burrell Behavioral Health to assist in developing of a system of care addressing both system and service issues. Through federal assistance the team has completed Logic Model Training. The team has formed several workgroups to look at training needs and best practices, assess service and system needs, enrollment and assessment and defining roles and responsibilities.

Butler Co. – A SOC Cooperative Agreement was developed across all departments whereas, team members mutually committed to cooperate in the development and implementation of the Butler Co. SOC. This group has been working on criteria for SOC referrals and identifying training needs for the policy team and child and family support teams across all agencies. (con't page 5)

Interesting Reading

The following are resources pertaining to mental health and/or juvenile justice.

Juvenile Offenders with Mental Health Disorders: Who are They? And What Do We Do With Them, a book by Lisa Melanie Boesky, Ph.D. Focuses primarily on juvenile offenders in residential facilities. The book can be obtained at **www.aca.org/publications/bookvideo.htm.**

Blueprints for Violence Prevention Overview - a large-scale prevention initiative, identifying model programs and providing training/technical assistance to help sites choose and implement a set of demonstrated effective programs with a high degree of integrity.
http://www.colorado.edu/cspv/blueprints/index.html

President's New Freedom Commission on Mental Health Issues Interim Report – result of public hearings on successes and failures of current mental health system. Final report due out in April. Interim report can be obtained on line at: www.mentalhealthcommission.gov/reports/Interim Report.htm.

Juvenile Residential Facility Census Report, 2000: Selected Findings –. http://www.ncrs.org/pdffiles1/ojjdp/196595.pdf

Checking Up On Juvenile Justice Facilities: A Best Practices Guide – a guide to teach child advocates about juvenile justice system, how to effectively educate the public and encourage development of community-based alternatives to incarceration. Available on line at: www.nmha.org/children/justjuv/checkingUpOnFacilities.pdf

Causes and Correlates of Delinquency Program Initiated in 1986 by OJJDP, three coordinated longitudinal projects., that identify variables associated with delinquency.
http://ojjdp.ncjrs.org/ccd/index.html

Community Perspectives on the Mental Health and Substance Abuse Treatment Needs of Youth Involved in the Juvenile Justice System: Commentary and Call To Action – A report on the Justice for Juveniles Initiative through National Mental Health Association.
www.nmha.org/children/justjuv/youth_treatment.pdf

Juvenile Arrests 2000 – Provides the latest statistics on juvenile crime rates. Shows that there has been a significant decrease in many categories of crimes committed by juveniles. Also provides comparison rates by race and gender.
http://www.ncjrs.org/pdffiles1/ojjdp/191729.pdf

Recommendations for Juvenile Justice Reform – Report of the Task Force on Juvenile Justice Reform of the American Academy of Child and Adolescent Psychiatry. Available on line at http://www.aacap.org/legislation/articles/everything6

OJJDP News at a Glance January/February 2003 Issues Includes information on grant funding opportunities and articles on services and supports for youth involved in the juvenile justice system. Contains information on how you can receive regular updates.
http://www.ncjrs.org/pdffiles1/ojjdp/198473.pdf

Missouri Alliance for Youth Steering Committee

Dolores Armstrong - Parent Representative
Patricia Carter, Ph.D. - DMH
Julie Cole-Agee - MO Juvenile Justice Association
Pat Doyen - Division of Youth Services
Ray Grush - 11th Circuit
Jim Harrison - Division of Family Services
Kathryn Herman - 22nd Circuit
Ed Morris - DMH/CPS
Gerald Poepsel - 20th Circuit
Dorn Schuffman - DMH
Kip Seely - 21st Circuit
Barb Smith - 33rd Circuit
Mike Waddle - 2nd Circuit
Gary Waint - Office of State Courts Administrator

SOC for Children, Youth and Families con't

Adair Co. – In Adair County the SOC team has been working diligently towards accepting their first referrals into SOC. The team has reviewed another counties referral form and modified it to more accurately reflect what was needed in Adair County.
Jackson Co. – The SOC team has been identifying services each agency would commit to support youth and working on development of interagency contracts to increase access to specific services.

Teams have also been developed on a voluntary basis in St. Charles and Jefferson County. These teams have identified committed resources from all agencies, addressed capacity issues and worked on interagency agreements/contracts to broaden the continuum of community-based services. Listed below are individuals you can contact to learn more about the philosophy and/or implementation of a Local System of Care team.

CONTACTS TO LEARN MORE ABOUT SYSTEM OF CARE

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